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# LEGISLATIVE DEVELOPMENTS: MEDICARE AND HEALTH CARE PROVIDERS' ANTI-UNIONIZATION COSTS—TO REIMBURSE OR NOT TO REIMBURSE—SECTION 107 OF TEFRA

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# COMMENT

## LEGISLATIVE DEVELOPMENTS: MEDICARE AND HEALTH CARE PROVIDERS' ANTI- UNIONIZATION COSTS—TO REIMBURSE OR NOT TO REIMBURSE— SECTION 107 OF TEFRA

### I. INTRODUCTION

*Employees of Hospital X wish to form a union in order to bargain collectively with their employer. Preferring to remain non-unionized, Hospital X seeks advice from Z, a consulting firm specializing in management representation on labor issues. Firm Z agrees to represent Hospital X and attempts to dissuade the employees from choosing to unionize. During that year, Z bills the hospital over \$49,000 for services rendered. Hospital X is then reimbursed in full for this cost by the medicare trust fund.<sup>1</sup>*

In January, 1982, the Health Care Financing Administration (HCFA)<sup>2</sup> of the United States Department of Health and Human Services (HHS)<sup>3</sup> announced that it would allow hospitals where employees were attempting to unionize to be reimbursed through medicare for costs incurred "in connection with union organizing

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1. *Stanford Univ. Hosp. v. Blue Cross Assoc.*, [New Developments] MEDICARE & MEDICAID GUIDE (CCH) ¶ 31,911, 9501 (PRRB Hearing Mar. 17, 1982), *aff'd in relevant part*, ¶ 31,990, 9821 (HCFA Deputy Administrator Decision May 12, 1982). In *Stanford University Hospital*, the provider had incurred a "claimed cost of \$49,432" for the services of a management consulting firm to repel the unionization efforts of its employees. *Stanford University Hospital*, ¶ 31,911 at 9503. These costs were allowed full medicare reimbursement, *id.* at 9504, due to the reversal in federal policy under the Reagan administration. See *infra* notes 43-49 and accompanying text.

2. The Health Care Financing Administration (HCFA) has been assigned by the United States Department of Health and Human Services (HHS) "the primary responsibility for administering the Medicare program." U.S. DEPT. OF HEALTH AND HUMAN SERVICES, HEALTH CARE FINANCING ADMINISTRATION, THIRTEENTH ANNUAL REPORT ON MEDICARE COVERING FISCAL YEAR 1979, ii (1979) [hereinafter cited as REPORT].

3. HHS was formerly the Department of Health, Education and Welfare (HEW); the redesignation occurred in 1979. Pub. L. No. 96-88, 93 Stat. 695 (codified at 20 U.S.C. § 3508 (1982)).

activities.”<sup>4</sup> Within eight months, Congress enacted the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA),<sup>5</sup> a provision of which expressly repudiated this policy.<sup>6</sup> Section 107 of TEFRA amended the medicare law<sup>7</sup> to prohibit any such medicare payment to hospitals for “costs incurred for activities directly related to influencing employees respecting unionization,”<sup>8</sup> thus ending an ongoing dispute over the issue of reimbursement of these costs to health care providers.<sup>9</sup>

This legislative-developments note examines the nature of that dispute as well as the chronology of administrative and congressional events culminating in the enactment of section 107. Through a brief description of the medicare reimbursement scheme and an analysis of the relevant policy considerations, this note demonstrates that health care employer activities conducted to prevent employee unionization should not be subsidized by federally-funded social programs. In addition, the shifting of power in the decision-making process over health care cost control will be discussed.<sup>10</sup>

## II. LEGISLATIVE AND ADMINISTRATIVE HISTORY

The issue of health care provider reimbursement arose in the

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4. Transmittal No. 261, § 2180.1 PROV. REIMB. MAN., Part 1 (Jan. 1982) *reprinted in* 1 MEDICARE & MEDICAID GUIDE (CCH) ¶ 5999Z-55 (1983). *See infra* notes 43-49 and accompanying text.

5. Pub. L. No. 97-248, 96 Stat. 324 (1982). President Reagan signed the Tax Equity & Fiscal Responsibility Act into law on September 3, 1982. *Id.*

6. Tax Equity & Fiscal Responsibility Act, 96 Stat. 337, section 107 (codified at 42 U.S.C.A. § 1395x(v)(1)(N) (West Supp. 1975-1982)).

7. Health Insurance for the Aged and Disabled, Title XVIII of the Social Security Act is codified at 42 U.S.C. §§ 1395-1395vv (1976 & Supp. V 1981) and 42 U.S.C.A. §§ 1395-1395vv (West 1974 & Supps. 1975-1982, 1983).

8. Tax Equity & Fiscal Responsibility Act, 96 Stat. 337, section 107 (to be codified at 42 U.S.C. § 1395x(v)(1)(N)).

9. “Provider” (of services) is a term of art defined in the medicare law as “a hospital, skilled nursing facility, comprehensive out patient rehabilitation facility, or home health agency. . . .” 42 U.S.C. § 1395x(u) (Supp. V 1981). The use of the term in this note encompasses the statutory definition.

10. The scope of this note is limited to medicare cost reimbursement for counter-unionization activities. Although provider reimbursement under the Medical Assistance Program (medicaid) presents a different statutory analysis, *see* 42 U.S.C.A. §§ 1396-1396n (West 1974 & Supps. 1975-1982, 1983), the policy rationales supporting prohibition of medicare reimbursement of “management” consultant fees are equally applicable to the medicaid program. *See Pressures in Today’s Workplace: Hearings to Examine Employer Practices which May Infringe on Employee Rights Before the Subcomm. on Labor-Management Relations of the House Committee on Education and Labor*, 96th Cong. 1st Sess. 188-200, 247-252 (1980) (Insertions: Medicare and Medicaid reimbursement claims by Massachusetts hospitals to cover costs of anti-union consulting services of Modern Management, Inc.)

context of a federal program designed to ensure the availability of adequate medical care<sup>11</sup> to specified categories of persons<sup>12</sup> within the United States.<sup>13</sup> Congress enacted title XVIII of the Social Security Act,<sup>14</sup> medicare, to provide a mechanism for national health insurance for the aged and disabled.<sup>15</sup> The program was intended to ensure needed health care through a government guarantee of payment of provider costs, a concept that surpassed mere reimbursement based on the charge for a specific treatment.<sup>16</sup>

Prior to 1974, medicare reimbursement for providers' persuasion costs<sup>17</sup> was not an issue because employees of nonprofit health care institutions were exempted from coverage under the National

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11. In 1965, an estimated 40.2 percent of non-federal hospitals were unaccredited by the health-care industry's standards. J. FEDER, *MEDICARE: THE POLITICS OF FEDERAL HOSPITAL INSURANCE* 9 (1977). While many of these hospitals lacked adequate staff or were unclean and unsafe, the largest barrier to accreditation appeared to have been "their overall failure to measure up to contemporary standards of technology, staffing, and medical practice." *Id.* Most of these substandard facilities were small hospitals located in less populated, poor, and rural communities. *Id.*

12. There are three categories of persons entitled by statute to receive medicare coverage:

(1) individuals who are age 65 or over and are eligible for retirement benefits under subchapter II of . . . [the Social Security Act] or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under subchapter II . . . or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

42 U.S.C.A. § 1395c (West Supp. 1975-1982).

13. S. REP. NO. 404, 89th Cong., 1st Sess. 23, *reprinted in* 1965 U.S. CODE CONG. & AD. NEWS 1943, 1964. Previous legislative efforts to ensure adequate medical care for the aged were found to be unsuccessful "because of the failure of some States to provide [medical] coverage and services to the extent anticipated." *Id.* Congress thus established "a more comprehensive Federal program as to both persons who can qualify and protection afforded." *Id.*

14. Title XVIII of the Social Security Act (as added July 30, 1965), Health Insurance for the Aged and Disabled, Pub. L. No. 89-97, 79 Stat. 291 (codified at 42 U.S.C.A. §§ 1395-1395vv (West 1974 & Supps. 1975-1982, 1983)).

15. *See, e.g.*, 42 U.S.C. § 1395c (Supp. V 1982) which describes the hospital and related care insurance; S. REP., *supra* note 13, at 23 *reprinted in* 1965 U.S. CODE CONG. & AD. NEWS 1943, 1964.

16. S. REP., *supra* note 13, at 23-24 *reprinted in* 1965 U.S. CODE CONG. & AD. NEWS 1964-65. Congressional intent was to "encourage participating institutions, agencies, and individuals to make the best of modern medicine more readily available to the aged." *Id.* at 24 *reprinted in* 1965 U.S. CODE CONG. & AD. NEWS 1965. Implicit in the passage of medicare was the congressional consensus "that the elderly could not afford needed care." FEDER, *supra* note 11, at 11. Accordingly, Congress rejected explicitly a "needs" test for medicare. S. REP., *supra* note 131, at 23 *reprinted in* U.S. CODE CONG. & AD. NEWS, at 1964.

17. The "cost of persuasion" is a term of art used in reference to any expenses incurred by a health care provider to resist employee unionization efforts. Throughout

Labor Relations Act (NLRA)<sup>18</sup> and were therefore less likely to organize successfully for collective bargaining purposes. Congress amended the NLRA in 1974<sup>19</sup> to extend to those health care workers the protection that had already been accorded employees of nursing homes and proprietary hospitals.<sup>20</sup> Because most non-government hospitals are classified as nonprofit institutions,<sup>21</sup> the 1974 NLRA amendment greatly expanded the scope of federal protection of labor union activities within the health care industry. Consequently, health care providers' expenses escalated in attempts to resist the increased unionization efforts of their employees.<sup>22</sup>

As medicare reimbursement principles are based upon the prov-

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this note, it usually connotes the employment by a health care provider of management consultants for this purpose.

18. For purposes of federal labor law coverage, the term "employer" previously was defined as:

any person acting as an agent of an employer, directly or indirectly, but shall not include the United States or any wholly owned Government corporation, or any Federal Reserve Bank, or any State or political subdivision thereof, [or any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual,] or any person subject to the Railway Labor Act . . . , as amended from time to time, or any labor organization (other than when acting as an employer), or anyone acting in the capacity of officer or agent of such labor organization.

Labor Management Relations Act of 1947, Pub. L. No. 80-101, § 2(2), 61 Stat. 136 (1947) (current version at 29 U.S.C. § 152(2) (1976)). The 1974 amendment to the NLRA amended the definition by removing the section in brackets quoted above. 29 U.S.C. § 152(2) (1976). The bracketed section was added specifically to remove non-profit hospital employees from the NLRA's original definition of the term "employer". National Labor Relations Act of 1935, Pub. L. No. 74-198, § 2(2), 49 Stat. 449, 450 (1935) *amended by* Pub. L. No. 80-101, § 2(2), 61 Stat. 137 (1947) (current version at 29 U.S.C. § 152(2) (1976)).

19. Pub. L. No. 93-360, 88 Stat. 395 (1974) (codified as amended at 29 U.S.C. § 152(2) and § 152(14) (1976)).

20. The 1947 amendment did not exempt from NLRA jurisdiction employees of proprietary hospitals. *See supra* note 18. *See also* Butte Medical Properties, 168 N.L.R.B. 266 (1967) (proprietary hospitals); University Nursing Home, Inc., 168 N.L.R.B. 263 (1967) (proprietary nursing homes). In *Drexel Home, Inc.*, 182 N.L.R.B. 1045 (1970), the National Labor Relations Board established its jurisdiction over labor relations activities in nonprofit nursing homes. *Id.* at 1047. Codifying this decision, the 1974 NLRA amendment defined the term "health care institution" to encompass "any hospital, health maintenance organization, health clinic, nursing home, extended care facility or other institution devoted to the care of sick, infirm, or aged persons." 29 U.S.C. § 152(14) (1976).

21. Tax avoidance is the main reason for this status. *See, e.g.*, HEALTH LAW CENTER, PROBLEMS IN HOSPITAL LAW 151-53 (1974). While federal and state hospitals are tax exempt due to statutory or constitutional provisions, other hospitals must fall within specific tax exempting provisions under federal or state law. *Id.* at 151-52.

22. *American Hosp. Assoc. v. Harris*, [New Developments] MEDICARE & MEDICAID GUIDE (CCH) ¶ 30,669, 10,731 (D.D.C. 1980). *See infra* notes 30-35 and accompanying text.

iders' actual incurred costs,<sup>23</sup> the federal government has had to develop a policy regarding these types of expenses.<sup>24</sup> No express position was announced initially by HHS, and it remains unclear whether the medicare fund at first was indemnifying hospital costs for opposing employee unionization.<sup>25</sup> In June, 1979, HCFA finally enunciated a two-pronged policy that would control the disposition of funds to health care providers whose reimbursement requests included such costs:<sup>26</sup> first, reasonable management costs were reimbursable when "incurred to carry out the providers' obligations under a collective bargaining agreement"<sup>27</sup> as these expenses were deemed to be directly related to the delivery of adequate health care;<sup>28</sup> second, and conversely, management activities that involved persuading employees not to unionize were considered unrelated to actual health care and therefore costs attributable to such persuasion activities would not be reimbursed under the medicare program.<sup>29</sup>

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23. See *infra* notes 82-86 and accompanying text.

24. Generally, these expenses were for retaining law firms and management consultants to assist the employer in repelling employee organization efforts. See, e.g., *American Hosp. Assoc. v. Harris*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 30,669, 10,731, 10,732 (D.D.C. 1980).

25. The American Hospital Association (AHA) alleged that "reimbursement for the expense of retaining lawyers, accountants, and consultants to *advise* providers of their rights and obligations during union organizing drives at health care facilities" had been authorized since the inception of medicare. *Id.* [emphasis added]. This allegation makes no specific reference to direct persuasion activities costs. Conversely, HHS maintained that the 1979 revision to the Provider Reimbursement Manual, see *infra* text accompanying notes 26-29, was the "traditional interpretation of the requirements contained in the statute and regulations." Notice of Policy Interpretation, 45 Fed. Reg. 69,561 (1980). Even though the revision was considered by HHS to be "a clarification of existing policy," fiscal intermediaries were advised to "reopen cost reports and make necessary adjustments to reflect this policy when they are aware of cases needing corrections. . . ." Transmittal No. 218, 1 MEDICARE & MEDICAID GUIDE (CCH) ¶ 5,999Z-56 (1983).

26. Notice of Policy Interpretation, 45 Fed. Reg. 69,561 (1980) (Prov. Reimb. Manual § 2180); Transmittal No. 218, § 2180.2 PROV. REIMB. MAN., Part 1 (1979) *reprinted in* 1 MEDICARE & MEDICAID GUIDE (CCH) ¶¶ 5999Z-55 to 56 (1983).

27. 45 Fed. Reg. 69,561 (1980) and 1 MEDICARE & MEDICAID GUIDE (CCH) ¶ 5999Z-56 (1979): The manual section states that:

Reasonable expenses incurred by a provider for collective bargaining and related activities are allowable costs. Contract negotiations and any procedures which flow from enforcement of contract terms, whether in a collective or individual setting, are necessary to maintain the continued operation of the provider and, thus, are a precondition for the delivery of health services.

*Id.* The manual provides the following example: "The cost of the services of management's representative in collective bargaining activities is an allowable cost." *Id.*

28. *Id.*

29. 45 Fed. Reg. 69, 561 (1980). Section 2180.1 of the Provider Reimbursement Manual as Transmitted in 1979 provides that:

Costs incurred for activities directly related to influencing employees regarding

In *American Hospital Association v. Harris*,<sup>30</sup> the American Hospital Association (AHA) challenged implementation of the rule, which was published as an addition to the Medicare Provider Reimbursement Manual, the government handbook of medicare reimbursement policies.<sup>31</sup> Suing on its members behalf,<sup>32</sup> the AHA raised both statutory<sup>33</sup> and constitutional claims<sup>34</sup> to void the new

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their right to organize or not to organize and to form a union or to join an existing union are not related to patient care and, therefore, are not allowable costs. Such costs are unallowable whether such activities are performed directly by the provider or through an independent contractor consultant or outside attorney.

*Id.* To clarify this position the manual presented the following example: "The costs applicable to a consultant who furnishes literature opposing union membership for provider employees or furnishes training to provider management to oppose employee membership in labor organizations are not allowable costs." *Id.*

30. [New Developments] MEDICARE & MEDICAID GUIDE (CCH) ¶ 30,669, 10,731 (D.D.C. 1980). The AHA is a nonprofit organization claiming a membership of approximately 6,200 health care institutions and 29,000 individuals. *Id.*

31. The Provider Reimbursement Manual is a collection of HHS interpretations and explanations of the medicare law and its regulations, utilized by HCFA, fiscal intermediaries and providers.

32. Civil Action No. 80-1202 was filed in the United States District Court, District of Columbia. *American Hosp. Assoc. v. Harris* at 10,731.

33. The AHA contended that the rule was adopted without notice or opportunity for interested parties to comment in violation of the Administrative Procedure Act (APA), 5 U.S.C. §§ 552-53 (1982). *American Hosp. Assoc. v. Harris* at 10,732-33.

Section 552(a)(1) as amended by the Freedom of Information Act requires that:

Each agency shall separately state and currently publish in the Federal Register for the guidance of the public . . .

(D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; and

(E) each amendment, revision, or repeal of the foregoing. Except to the extent that a person has actual and timely notice of the terms thereof, a person may not in any manner be required to resort to, or be adversely affected by, a matter required to be published in the Federal Register and not so published. . . .

5 U.S.C. § 552(a)(1) (1982). Although section 4 of the APA (regarding rule making) is not applicable, through its language, to matters relating to federal "benefits" programs, *id.* § 553(a)(2) (1982), the Secretary of the HEW had waived the agency's exemption from this section. 36 Fed. Reg. 2,532 (1971). *See also* *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070, 1084 (D.C. Cir. 1978). By waiver of this exemption, 5 U.S.C. § 553(b) is applicable:

General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include—

(1) a statement of the time, place, and nature of public rule making proceedings;

(2) reference to the legal authority under which the rule is proposed; and

(3) either the terms or substance of the proposed rule or a description of

policy. The AHA complaint survived the government's motion to dismiss for want of subject-matter jurisdiction,<sup>35</sup> although a judicial decision on the merits was never reached because subsequent administrative action mooted the challenge.

In a blatant attempt to purge the substance from AHA's pending claim, HCFA initiated notice and comment rulemaking procedures.<sup>36</sup> Shortly after the district court upheld its jurisdiction over AHA's claims,<sup>37</sup> HCFA issued through the Federal Register a "Notice of Policy Interpretation" that reprinted and explained the 1979 revision of the Reimbursement Manual regarding labor relations costs.<sup>38</sup> At the conclusion of the comment period,<sup>39</sup> HCFA nonetheless announced the retention of the two-tiered policy.<sup>40</sup> Medicare payment for the cost of persuasion would continue to be disallowed, but actual collective bargaining costs would be reimbursable.<sup>41</sup> The

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the subjects and issues involved. Except when notice or hearing is required by statute, this subsection does not apply—

(A) to interpretative rules, general statements of policy, or rules or agency organization, procedure, or practice; or

(B) when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.

5 U.S.C. § 553(b) (1982). Further, after the required notice is given, "the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation." *Id.* § 553(c).

34. AHA claimed that lack of notice and an opportunity to comment, as well as the proposed retroactive application of the rule, violated the fifth amendment's due process clause. *American Hosp. Assoc. v. Harris*, at 10,732-33.

35. FED. R. CIV. P. 12(b)(1). The U.S. District Court's order based its subject matter jurisdiction under 28 U.S.C. § 1331 (1976) as federal questions were raised pursuant to 5 U.S.C. §§ 552-53 (1982) and the fifth amendment. *American Hosp. Assoc. v. Harris* at 10,735. While 5 U.S.C. § 702 of the APA did not provide an independent basis for federal court jurisdiction in this case, *id.*, the AHA was not required to exhaust administrative remedies as the claim was brought "solely to vindicate procedural regularity." *Id.* at 10,734. *See also* 42 U.S.C. § 405(h) (1976) and 42 U.S.C. § 1395oo (1976 & Supp. V 1981).

36. *See supra* note 33; 5 U.S.C. § 553 (1982).

37. The order was entered on September 16, 1980. *American Hosp. Assoc. v. Harris* at 10,735.

38. 45 Fed. Reg. 69,561 (1980). The notice solicited "public comment on current HCFA policy with respect to Medicare reimbursement for provider costs incurred with respect to union activities." *Id.*

39. *See* Final Notice, 46 Fed. Reg. 3,983 (1981).

40. *Id.* at 3,984.

41. *Id.* The notice distinguished the two types of costs:

Provider negotiations with provider employees with respect to wages, benefits and conditions of employment are clearly necessary to delivery of patient care whether conducted through individual or collective bargaining. The same is



HCFA expressed its intention to clarify this rule further,<sup>42</sup> yet that communication was never forthcoming. Instead, HCFA, under the direction of President Reagan's appointees in HHS,<sup>43</sup> reversed course with another revision of the Provider Reimbursement Manual:<sup>44</sup> "Reasonable costs incurred in furtherance of the rights and responsibilities of provider employers or employees under the . . . [NLRA are] allowable costs of operation. Provider facilities whose employees are not unionized may incur costs in connection with union organizing activities."<sup>45</sup> While persuasion costs would be reimbursed under this standard, the revision disallowed any medicare payment of health care institutional costs incurred due to activities found to violate the NLRA.<sup>46</sup>

Administrative convenience and consistency with national labor policy as expressed through the NLRA were the policy reasons articulated to support reversal of a seemingly well-settled rule.<sup>47</sup> To accomodate the medicare statutory requirements, HHS in essence defined "reasonable costs incurred in connection with union organizing activities" as provider expenses sufficiently related to patient care to warrant medicare funding.<sup>48</sup> Additionally, the reversal was effective retroactively: Costs previously disallowed under the former 1979 rule would be reconsidered and, if otherwise reasonable, would be reimbursed through medicare.<sup>49</sup>

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not true for activities designed to influence employees with respect to whether or not to conduct their negotiations with the provider on an individual or a collective basis, since either basis can be and is used in the provision of patient care.

*Id.*

42. *Id.* at 3,985.

43. In early 1981, Richard Schweiker, appointed by President Reagan, replaced Patricia Harris as Secretary of Health and Human Services. Two years later, Schweiker resigned the HHS post to accept a position as president of the American Council on Life Insurance, an insurance industry trade association. N.Y. Times, Jan. 12, 1983, at A1, col. 3.

44. Transmittal No. 261, *supra* note 4, ¶ 5999Z-55.

45. *Id.*

46. *Id.* "Costs claimed for activities which are not authorized, or which are prohibited by the NLRA will continue to be disallowed as unreasonable and unrelated to the efficient delivery of needed health services." *Id.*

47. *Id.*

48. *Id.* Requiring reimbursable cost to be 'reasonable' supplements the other explicit statutory requirement that the cost in question must bear a sufficient relationship to treatment of medicare recipients. 42 U.S.C.A. § 1395x(v)(1)(A) (West Supp. 1975-1982).

49. Transmittal No. 261, *supra* note 4, at ¶ 5999Z-55. "Cost reports [should be reopened] where intermediaries had disallowed costs under Transmittal No. 218, dated June 1979, but which would be considered allowable and reasonable under this issuance." *Id.*

Predictably, labor unions protested vehemently the new reimbursement policy. Despite HHS pronouncements to the contrary,<sup>50</sup> organized labor viewed with alarm both the anti-union message conveyed by the executive branch of the federal government and the new policy's anticipated effect upon government neutrality in labor-management matters.<sup>51</sup> During a hearing of the House Labor Subcommittee on Labor-Management Relations, organized labor's dissent focused on its objection to the subsidization of anti-union activities with funds collected from working taxpayers.<sup>52</sup> In addition, House leaders urged the HHS Secretary to reinstate the former rule.<sup>53</sup> HHS, however, failed to indicate that the policy would be reformed.

Members of the House of Representatives then proposed an amendment to the medicare law designed to reverse the new policy favoring reimbursement of persuasion costs.<sup>54</sup> Meanwhile, the Senate Finance Committee considered measures to reduce the widening federal budget deficit.<sup>55</sup> Consolidating its proposals, the Senate Finance Committee substituted its package for the text of H.R. 4961, a minor House-passed bill awaiting Senate consideration.<sup>56</sup> After the

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50. See, e.g., [Current reports] GOV'T. EMPL. REL. REP. (BNA) 958:20 (Apr. 12, 1982).

51. *Id.* at 958:21.

52. *Id.* Leaders of organized labor characterized the new reimbursement policy as "illegal and immoral" and a governmental legitimization of the practice of "union busting". *Id.*

53. *Id.*

54. See House Ways and Means Committee Print reprinted in 4 MEDICARE & MEDICAID GUIDE (CCH) ¶ 24,513 (1982). The purpose of the proposal was to prohibit Medicare reimbursement for costs incurred for activities directly related to influencing employees respecting proposed unionization. Thus, costs incurred for activities related to influencing employees regarding their right to organize, to form a union, or to join a union would not be considered reasonable. Such costs would not be allowable whether performed directly by the provider or through contracts with consultants or attorneys.

*Id.*

55. The estimated federal budget deficits at the time of passage of the Act were \$182 billion in fiscal year (FY) 1983, \$216 billion in FY 1984, and \$233 billion in FY 1985. 128 CONG. REC. H6555 (daily ed. Aug. 19, 1982) (statement of Rep. Rostenkowski).

56. This procedure raises a question under the Constitution's revenue-raising origination clause which states that: "All Bills for raising Revenue shall originate in the House of Representatives; but the Senate may proposed or concur with Amendments as on other Bills." U.S. CONST. art. I, § 7, cl. 1. The constitutionality of bills that have originated in substance in the Senate has been upheld previously by the Supreme Court.

In *United States v. Norton*, 91 U.S. 566 (1876), the Court encountered a challenge to an embezzlement indictment for violation of a federal revenue law that had been passed under similar circumstances to H.R. 4961. Holding that the "Act to establish a postal

full Senate approved the Finance Committee's recommendations, the essentially brand-new measure went directly to joint conference without a prior House vote as House Democrats attempted to avoid political fallout for enacting a tax increase in an election year.<sup>57</sup> Although the Senate Parliamentarian had ruled that the scope of the conference was limited solely to addressing the Senate-passed bill,<sup>58</sup>

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money-order system" was not a revenue bill in the constitutional sense, the *Norton* Court stated that the meaning of revenue laws, for article I purposes, "has been confined to bills to levy taxes in the strict sense of the words, and has not been understood to extend to bills for other purposes which [may] incidentally create revenue." *Id.* at 569 (quoting 2 J. STORY, COMMENTARIES ON THE CONSTITUTION OF THE UNITED STATES § 880, 610-11 (1858)).

The Corporation Tax Law of the Payne-Aldrich Tariff Act of 1909, Pub. L. No. 61-5, § 38, 36 Stat. 112 (1909), also originated as a Senate measure substituted for provisions in a House general revenue bill. *Flint v. Stone Tracy Co.*, 220 U.S. 107, 142-43 (1911). Since "[t]he amendment was germane to the subject-matter of the [House] bill and not beyond the power of the Senate to propose," the Court decided that article I, section 7 was not violated because the actual bill itself "properly originated in the House." *Id.* at 143. In *Flint* the Court professed great deference to the legislative process (at least on this particular constitutional issue):

In thus deciding, we do not wish to be regarded as holding that the journals of the House and Senate may be examined to invalidate an act which has been passed and signed by the presiding officers of the House and Senate and approved by President and duly deposited with the State Department.

*Id.*

When the issue identical to that in *Flint* arose three years later, the Court held *inter alia* that a revenue raising bill "originating in the Senate and not in the House of Representatives" did not violate article I, section 7: The bill had been "proposed by the Senate as an amendment to a bill for raising revenue which [had] originated in the House." *Rainey v. United States*, 232 U.S. 310, 317 (1914). The *Rainey* Court expressed doubt as to whether "there is judicial power after an act of Congress has been duly promulgated to inquire in which House it originated for the purpose of determining its validity . . . ." *Id.* These cases indicate that the validity of the Tax Equity and Fiscal Responsibility Act, which evolved from an amendment to H.R. 4961, a House-passed revenue measure, could not be challenged successfully under article I's origination clause. In any event, the substantive changes made by the bill in health and income security programs are not revenue raising measures under the *Norton* test and thus, could be severed from any 'offending' part of the Act. Moreover, section 107 of the Tax Equity Act, like most of the medicare provisions did in fact originate in the House of Representatives. *See supra* note 54 and accompanying text.

57. *See Tate, Legislative Legend-Making, Tax Bill Style*, 40 CONG. Q. 2043 (Aug. 21, 1982). This fact did not go unnoticed by those House members in opposition to H.R. 4961 in its final form:

Not only has the House of Representatives not had an opportunity to discuss, debate or amend provisions of this bill prior to action on this conference report, but the House committee of jurisdiction the Ways and Means Committee, has not even held hearings on most of the items contained within this proposal.

128 CONG. REC. H6596 (daily ed. Aug. 19, 1982) (statement of Rep. Fields).

58. *Tate, supra* note 57, at 2043.

other previous House-approved measures,<sup>59</sup> including the anti-unionization cost reimbursement ban, were incorporated within the final version of H.R. 4961.<sup>60</sup>

H.R. 4961 thus became the Tax Equity and Fiscal Responsibility Act of 1982 and passed both houses of Congress on August 19, 1982.<sup>61</sup> A politically veto-proof measure,<sup>62</sup> TEFRA was signed into law by President Reagan on September 3, 1982.<sup>63</sup> Section 107 of TEFRA amended section 1861(v)(1) of the Social Security Act to provide that in determining reasonable costs for medicare reimbursement, "costs incurred for activities directly related to influencing employees respecting unionization may not be included." Thus, as a result of this congressional mandate, HHS is required to return to its former rule against reimbursement to health care providers for the costs of counter-unionization activities.

### III. MEDICARE COST REIMBURSEMENT PRINCIPLES

Congressional legislation and regulatory schemes govern which costs will be allowable for reimbursement from medicare funds. HCFA, under HHS, is charged with responsibility for the execution of the national health care system. The core element of that responsibility is the determination of what constitutes "reasonable costs", the issue most basic to the fiscal integrity of the medicare program.

The essence of a functioning government-sponsored health care system is the determination of which costs of care will be met. That the program's policy objectives are manifested by the established reimbursement principles is axiomatic. With that understanding, Congress enacted the Health Insurance for the Aged Act, also known as medicare.<sup>64</sup> Medicare consists of two federal insurance programs that assist aged and disabled individuals with payment of health care

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59. *See id.*

60. Estimated savings over a three year period from amendments to income maintenance and health programs were as follows: \$13.3 billion, medicare; \$1.1 billion, medicaid; and a combined \$791 million in Supplemental Security Income (SSI), Aid to Families with Dependent Children (AFDC), and unemployment compensation. H.R. REP. NO. 760, 97th Cong., 2d Sess. 464, *reprinted in* 1982 U.S. CODE CONG. & AD. NEWS 412, 466. *See also* 128 CONG. REC. H6549, H6556 (daily ed. Aug. 19, 1982) (statements of Representatives Ottinger and Rostenkowski).

61. 128 CONG. REC. H6635-36 and S10945-46 (daily ed. Aug. 19, 1982).

62. Anxious to reduce the widening gap between spending and the federal budget projections, the Reagan administration desperately needed a revenue-raising measure to exhibit some control over deficit spending. *See supra* note 55.

63. *E.g.*, 96 Stat. 324 (1982).

64. *See supra* notes 7-16 and accompanying text.

bills: Part A, Hospital Insurance Benefits;<sup>65</sup> and Part B, Supplementary Medical Insurance.<sup>66</sup>

Part A "provides basic protection against the costs of hospital and related post-hospital and home health services."<sup>67</sup> These benefits cover specific statutorily defined services.<sup>68</sup> Certain requirements, however, are placed upon the health care providers.<sup>69</sup> Medicare law also limits the reimbursement of the provider to its "reasonable costs" of rendering services to medicare recipients.<sup>70</sup> Within the framework established by Congress, the Secretary of HHS promulgates regulations, defining more specifically which costs are deemed to be reasonable.<sup>71</sup> The providers generally submit claims for reimbursement to private intermediaries who then determine the amount of reimbursement in accordance with the Department's rules and regulations.<sup>72</sup> Financed through a wage tax<sup>73</sup> similar to, but separate from, social security taxes, Part A's contributions have been segregated into the Federal Hospital Insurance Trust Fund.<sup>74</sup>

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65. 42 U.S.C.A. §§ 1395c through 1395i-2 (West 1974 & Supps. 1975-1982, 1983). For eligibility requirements, *see id.* § 1395c; Hospital Insurance Benefits, 42 C.F.R. §§ 405.101-105 (1982).

66. 42 U.S.C.A. §§ 1395j-1395w (West 1974 & Supp. 1975-1982). For eligibility requirements, *see id.* § 1395o; Supplementary Medical Insurance Benefits, 42 C.F.R. §§ 405.201-206 (1982).

67. 42 U.S.C.A. § 1395c (West Supp. 1975-1982).

68. *Id.* § 1395d. *See id.* § 1395e for the law regarding deductibles and coinsurance. The regulations relevant to the scope of benefits under the medicare law are at 42 C.F.R. §§ 405.110-133 (1982).

69. 42 U.S.C.A. § 1395f(a) (West 1974 & Supps. 1975-1982, 1983). The following regulations state the requirements to participate in the medicare program: For hospitals, 42 C.F.R. §§ 405.1011-1040 (1982); for skilled nursing facilities, *id.* §§ 405.1101-1137; for home health agencies, *id.* §§ 405.1201-1230; for clinics, rehabilitation agencies, and public health agencies, *id.* §§ 405.1701-405.1726. Regulations governing provider certification and recertification include 42 C.F.R. §§ 405.1625-1634 (1982).

70. 42 U.S.C.A. § 1395f(b) (West Supps. 1975-1982, 1983); 42 C.F.R. § 405.151 (1982). By adopting a "reasonable cost" standard for reimbursement, Congress merely was following the then accepted practice of most health insurers. FEDER, *supra* note 11, at 2, 53. This standard assures that hospitals generally would receive from medicare more than just the basic charge for providing a specific type of care. *See supra* note 16 and accompanying text.

71. 42 U.S.C.A. § 1395x(v)(1)(A) (West Supp. 1975-1982). *See infra* notes 91-106 and accompanying text.

72. *See* 42 U.S.C.A. § 1395h (West 1974 & Supp. 1975-1982); *see also* REPORT, *supra* note 2, at 11.

73. Ninety-one per cent of Part A hospital insurance is financed through this wage tax on employers, employees and the self-employed. REPORT, *supra* note 2, at ii and 9. General revenues and other sources provide funds for the remaining nine percent of Part A. *Id.* at 9.

74. 42 U.S.C.A. § 1395i (West 1974 & Supps. 1975-1982, 1983). The "Board of

Part B, on the other hand, is a voluntary supplemental medical insurance program financed by premiums paid by its enrollees.<sup>75</sup> Its coverage extends to a portion of the cost of physician care and other health items and services not within the statutory scope of Part A.<sup>76</sup> Administratively analogous to the hospital insurance,<sup>77</sup> reimbursement to providers for services rendered within the realm of Part B generally is determined by carriers under contract with HHS.<sup>78</sup>

In both of these programs, the responsibility for determining the nature of patient care required rests primarily with the physician.<sup>79</sup> The underlying policy was not to have the federal government dictate per se the specific treatment required for a patient.<sup>80</sup> Rather, Congress intended that the reimbursement of provider costs would furnish the governmental controls needed to ensure implementation

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Trustees of the Trust Fund" is responsible for "holding" the fund, reporting on its operation and status to Congress, and reviewing policies in the fund's management. *Id.* § 1395i(b). Ex officio members of the board include Secretary of the Treasury, Secretary of Labor, and Secretary of Health and Human Services. *Id.* The Treasury Secretary is designated the "Managing Trustee" while the Administrator of the Health Care Financing Administration serves as "Secretary of the Board". *Id.* Annual board reports made to Congress are to "be printed as a House [of Representatives] document of the session of the Congress to which the report is made." *Id.*

75. 42 U.S.C. § 1395j (1976); 42 C.F.R. § 405.201 (1982). *See supra* note 66 for eligibility requirements.

76. 42 U.S.C.A. § 1395k (West 1974 & Supp. 1975-1982); 42 C.F.R. §§ 405.230-.239 (1982).

77. *See* 42 U.S.C.A. § 1395n (West 1974 & Supp. 1975-1982, 1983).

78. *Id.* § 1395u. *See also* REPORT, *supra* note 2, at 11.

Physicians generally are reimbursed on a "reasonable charge" basis for services rendered to medicare recipients. For a detailed discussion of the distinguishing criteria for establishing reasonable costs to providers as compared to reasonable charges for physicians, see 48 Fed. Reg. 8,902-35 (1983).

79. *Breeden v. Weinberger*, 377 F. Supp. 734 (D. La. 1974). In *Breeden* the court noted three principles to be considered in determining whether the medicare act embraces certain services rendered to a patient: (1) the totality of the patient's condition; (2) the great weight to be given a physician's opinion absent contrary evidence; and (3) the placing of responsibility on the attending physician for the choice of care required. *Id.* at 737. *See* 42 U.S.C. § 1395 (1976) which prohibits federal interference in "the practice of medicine or the manner in which medical services are provided." *Id.* As a precondition to participation in the medicare program, however, providers are required to conform to state and local laws. 42 C.F.R. §§ 405.1020, 405.1120, 405.1220 (1982). Additionally, skilled nursing facilities and home health care agencies must comply "with all federal, state, and local laws relating to fire and safety, sanitation, communicable and reportable diseases, post-mortem procedures, and other relevant health and safety requirements." *Id.* § 405.1120; *see also id.* § 405.1220.

80. 42 U.S.C. § 1395 (1976). *See also* FEDER, *supra* note 11, at 33-45 regarding the development of the "utilization review" principle. 42 U.S.C.A. § 1395x(k) (West 1974 & Supp. 1975-1982). Thus, use of provider facilities would be reviewed and evaluated by its own staff committee, not a federal review team, unless "it is impracticable for the institution" to form such a review team. *Id.* § 1395x(k).

of the program's overall goal, ensuring the availability of competent health care to the nation's aged or disabled.<sup>81</sup>

While Congress has delegated broad authority to the Secretary of HHS to establish rules and regulations in determining which costs would be found reasonable,<sup>82</sup> the statutory definition of the term "reasonable costs" provides certain criteria that must be considered by the administering agency.<sup>83</sup> By congressional direction, the regulations must

take into account both direct and indirect costs of providers of services . . . in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established . . . [under medicare] will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by [medicare funds] . . .<sup>84</sup>

Additionally, in an effort to create an economic incentive to provider cooperation, Congress requires HHS to make "suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive."<sup>85</sup> This requirement allows issuance of timely payments, subject to retroactive readjustments, to providers.<sup>86</sup>

Section 107 of TEFRA serves as another direct Congressional limitation on the authority of the executive branch to define what constitutes a "reasonable cost".<sup>87</sup> Despite the maxim that the ad-

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81. See *supra* notes 14-16 and accompanying text.

82. *E.g.*, *Marina Mercy Hosp. v. Harris*, 633 F.2d 1301, 1304 (9th Cir. 1980).

83. 42 U.S.C.A. § 1395x(v)(1)(A) (West Supp. 1975-1982).

84. *Id.* See also *supra* notes 95 and 99 and accompanying text.

85. 42 U.S.C.A. § 1395x(v)(1)(A) (West Supp. 1975-1982).

86. Under 42 C.F.R. § 405.405(a) (1982) the provider will receive "interim payments", usually at an estimated rate of its overall reimbursable costs. *Id.* Section 405.405(c) (1982) provides that

interim payments to providers will be made for services throughout the year, with final settlement on a retroactive basis at the end of the accounting period. Interim payments will be made as often as possible and in no event less frequently than once a month. The retroactive payments will take fully into account the costs that were actually incurred and settle on an actual, rather than on an estimated basis.

*Id.*

87. *E.g.*, *Kingsbrook Jewish Medical Center v. Richardson*, 355 F. Supp. 965, 966 (E.D.N.Y.), *rev'd on other grounds*, 486 F.2d 663 (2d Cir. 1973): Section 1395x(v) is subject to 42 U.S.C. § 1395e. *Id.* at 966. See also 42 U.S.C.A. § 1395x(v) (West 1974 & Supp. 1975-1982) for other examples of congressional "fine-tuning" of the definition of "reasonable costs."

ministering authority, with all its expertise, knows best how to implement congressional policy,<sup>88</sup> section 107 obviously is consistent with the rule that agency determinations must bear a reasonable relation to the legislative purpose of the statute.<sup>89</sup> A similar consideration is that regulations promulgated under medicare must be within the statutory authority delegated to the HHS Secretary by Congress.<sup>90</sup>

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88. *E.g.*, *Udall v. Tallman*, 380 U.S. 1, 16 (1965). "When faced with a problem of statutory construction, this Court shows great deference to the interpretation given the statute by the officers or agency charged with its administration . . . When the construction of an administrative regulation rather than a statute is in issue, deference is even more clearly in order." *Id.* at 16. *Accord* *American Hosp. Management Corp. v. Harris*, 638 F.2d 1208, 1212 (9th Cir. 1981) (upholding disallowance of reimbursement for rental payment costs to a "related organization"); *Methodist Hosp. of Indiana, Inc. v. United States*, 626 F.2d 823, 826 (Ct. Cl. 1980) (affirming denial of reimbursement for "certain accrued pension plan costs").

Congress has the power to effectuate, within constitutional limits, any legislation to define its previous enactments. *E.g.*, U.S. CONST. art. I, § 8, cl. 18.

89. *See* *American Ship Bldg. Co. v. NLRB*, 380 U.S. 300 (1965) in which the Court held that it was not an unfair labor practice under the NLRA for an employer to shut down its plant during an impasse solely to support its bargaining position. *Id.* at 313. In rejecting the NLRB's position, the Court stated that "[t]he deference owed to an expert tribunal cannot be allowed to slip into a judicial inertia which results in the unauthorized assumption by an agency of major policy decisions properly made by Congress." *Id.* at 318. *See* *Volkswagenwerk Aktiengesellschaft v. Federal Maritime Comm'n*, 390 U.S. 261, 272, *modified on reh'g*, 392 U.S. 901 (1968) ("courts are the final authorities on issues of statutory construction"); *see also* *Diplomat Lakewood, Inc. v. Harris*, 613 F.2d 1009 (D.C. Cir. 1979) in which the court invalidated as arbitrary, capricious and not in accordance with law, regulations that required large independent nursing homes to use cost computation methods different from and arguably less accurate than those demanded of large hospitals and large hospital-nursing home complexes. *Id.* at 1011.

A "reasonable cost" regulation was challenged recently in *American Hospital Management Corp. v. Harris*, 638 F.2d 1208 (9th Cir. 1981); the court found that the regulation fulfilled the objectives of the relevant enabling legislation and, thus, was valid within the statutory framework. *Id.* at 1213. The court enunciated its standard of review of such medicare regulations:

Our review of the validity of that regulation is limited to determining whether the regulation is reasonably related to the purpose of the relevant enabling legislation, as well as to the more particular purpose through which the regulation implements those objectives in a particular area . . . [T]he regulation . . . may not achieve its objective with mathematical precision . . . It is well established, however, that this . . . will not invalidate the regulation.

*Id.* at 1212.

90. In *Chrysler Corp. v. Brown*, 441 U.S. 281 (1979) (Rehnquist, J.), the Court restated the basic rule: "The legislative power of the United States is vested in Congress, and the exercise of quasi-legislative authority by governmental departments and agencies must be rooted in a grant of such power by the Congress and subject to limitations which that body imposes." *Id.* at 302. *See also* *Batterton v. Francis*, 432 U.S. 416 (1977), in which the Court upheld an HEW regulation that allowed states to deny unemployment-based AFDC to "persons disqualified under unemployment compensation laws. . . ." *Id.* at 429.

Constitutional attacks on the substance of regulatory provisions governing entitle-



While mandating the reimbursement principles for provider costs<sup>91</sup> of services rendered to medicare beneficiaries, the medicare regulatory scheme, binding on fiscal intermediaries,<sup>92</sup> is designed to provide flexibility in most instances.<sup>93</sup> Medicare reimbursement to providers is to be made for "[a]ll necessary and proper expenses of an institution in the production of services, including normal standby costs. . . ." <sup>94</sup> The charges to the program are to be apportioned, however, so that medicare pays "the share of the total institutional cost that . . . is related to the care furnished [medicare] beneficiaries. . . ." <sup>95</sup>

The medicare regulations contemplate the accomplishment or use of six objectives or tests in the establishment of cost reimbursement principles:<sup>96</sup> (1) current payment to providers of services;<sup>97</sup> (2) full accounting of actual costs through retroactive adjustment;<sup>98</sup>

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ment programs have not fared well. *E.g.*, *Dandridge v. Williams*, 397 U.S. 471 (1970). A majority of the Burger Court has "been reluctant to impose affirmative governmental obligations to redress economic inequalities." L. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 1004 (1978). Consequently, challenges to public assistance regulations generally are based on statutory grounds, *e.g.*, *Morton v. Ruiz*, 415 U.S. 199, 232-33 (1974), or on fifth amendment procedural due process grounds, *e.g.*, *Himpler v. Califano*, 611 F.2d 137 (6th Cir. 1979). *See also* 5 U.S.C. § 706(2)(C) (1976) (scope of judicial review under the APA includes questions of statutory jurisdiction, authority, limitations, or right).

91. 42 C.F.R. § 405.401(a), (b) (1982).

92. *Id.* § 405.401(c).

93. *Id.* § 405.401(d). This regulation provides that:

In consideration of the wide variations in size and scope of services of providers and regional differences that exist, the [reimbursement] principles are flexible on many points. They offer certain alternatives and options designed to fit individual circumstances and to allow time for those providers who do not already collect the statistical and financial data necessary for the reporting of costs to develop the necessary records.

*Id.*

94. *Id.* § 405.402(a). To ensure equity and fairness to providers, "payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate." *Id.* But see *infra* text accompanying notes 170-72.

95. 42 C.F.R. § 405.402(a) (1982). In *Good Luck Nursing Home, Inc. v. Harris*, 636 F.2d 572 (D.C. Cir. 1980), the court held that reimbursement was not available under medicare law "for legal and related expenses incurred unsuccessfully defending against an action for fraud arising out of . . . [the provider's] participation in that program." *Id.* at 575. The court noted further that the "statutory objective" for 42 U.S.C. § 1395x(v)(1)(A) was "to ensure that the Medicare program bears the full and actual cost of providing care for its beneficiaries but none of the cost of providing health care to anyone else." *Id.* *See also* 42 C.F.R. § 405.403 (1982) (apportionment of allowable costs); *id.* § 405.404 (methods of apportionment under medicare).

96. 42 C.F.R. § 405.402(b) (1982).

97. *Id.* § 405.402(b)(1). This objective is designed to prevent the providers from "having to put up money for the purchase of goods and services well before they receive reimbursement." *Id.* *See supra* notes 85-86 and accompanying text.

98. 42 C.F.R. § 405.402(b)(2) (1982). The adjustment is designed to account fully

(3) allocation of costs between medicare beneficiaries and other patients;<sup>99</sup> (4) flexibility in reimbursement methods;<sup>100</sup> (5) equitable treatment regardless of provider's proprietary status;<sup>101</sup> and (6) necessity for provider's growth and adjustment for technological advancement.<sup>102</sup> Ultimately, the issue of reimbursement is dependent upon a determination that a particular cost is related to the care of medicare patients and that the cost is "necessary and proper".<sup>103</sup> Although the federal government relies on private carriers, especially in the supplementary insurance program,<sup>104</sup> to assist directly in the administration of medicare, these carrier-intermediaries nevertheless are bound to follow the rules and regulations as prescribed by HHS.<sup>105</sup> Reasonable cost criteria as defined by statute and regulation are the guiding principles to all parties involved in the financial administration of medicare.<sup>106</sup>

#### IV. TO REIMBURSE OR NOT TO REIMBURSE: POLICY CONSIDERATIONS

Underlying any HHS rule of medicare reimbursement for health care provider costs is a policy-laden rationale based primarily on furthering the program's ultimate goals. The unionization cost question, however, also requires consideration of national labor policy. During the period of policy formulation of the unionization-cost issue, many factors were weighed in HHS's original decision not to

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for "increases in cost . . . as they actually occurred, not just prospectively." *Id.* See *supra* notes 85-86 and accompanying text.

99. 42 C.F.R. § 405.402(b)(3) (1982). See *supra* note 95 and accompanying text. See also *Board of Regents v. Califano*, 586 F.2d 451 (5th Cir. 1978) for a clear explanation of the theory behind and operation of the cost apportionment principle.

100. 42 C.F.R. § 405.402(b)(4) (1982). See *supra* note 93 and accompanying text.

101. 42 C.F.R. § 405.402(b)(5) (1982).

102. *Id.* § 405.402(b)(6).

103. *Id.* § 405.451(a). This regulation provides in part:

All payments to providers of services must be based on the reasonable cost of services covered under title XVIII of the [Social Security] Act and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost.

*Id.*

104. See *id.* §§ 405.501 and 405.502(d) (1982).

105. *Id.* § 405.401.

106. See *supra* text accompanying notes 82-86. Reimbursement for Part B covered services, particularly when the provider is a "non-participant" in the medicare program, is made on the basis of a "reasonable charge" standard. 42 C.F.R. § 405.501 (1982). The payment may be made directly to the individual beneficiary, *id.* § 405.251(a), or rather to the "person who furnished the services." *Id.* § 405.251(b). The regulations contain the criteria for determining "reasonable charges". *Id.* § 405.502.

reimburse a hospital's anti-unionization costs.<sup>107</sup> Relevant also to section 107 of TEFRA, these factors appropriately may be examined in light of that provision's ban on medicare reimbursement for health care providers' unionization costs.

*A. Consistency with Existing Federal Law and Policy*

The initial HHS decision not to reimburse providers' counter-unionization costs reflected the basic legislative premise underlying the medicare program: Medicare funds are available only for the costs of delivering health care to recipients.<sup>108</sup> Because the providers' preference to employ unorganized workers is unrelated to the purpose of medicare, the original 1979 HHS pronouncement was entirely consistent with the statutory scheme established by Congress.

The January, 1982, decision to overturn that pronouncement was based on assuring some congruity in national policy; if the provider conduct surrounding unionization activities was not censurable under federal labor law, such provider activity should not be discouraged through the federal medicare reimbursement scheme.<sup>109</sup> Reagan administration officials contended that the inconsistency caused by a policy of nonallowance was indicative of bureaucratic overregulation beyond legitimate legislative goals.<sup>110</sup> Yet, while the NLRA<sup>111</sup> represents a congressional expression of national labor policy,<sup>112</sup> medicare reimbursement is an unrelated mechanism designed to further national health care objectives. Legislation can be legitimately enacted in different, but intersecting, spheres of influence. Aware of the consequences of its law-making power, Congress can ensure that, in appropriate situations, proposed legislation will mesh with established laws in these overlapping areas. Such was not the case here, however, as the passage of the medicare act in 1965

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107. See 46 Fed. Reg. 3,983 (1981); see *supra* notes 50-53 and accompanying text.

108. See *supra* notes 95, 99 and accompanying text.

109. See *supra* note 4 and accompanying text.

110. *Id.*

111. 29 U.S.C. §§ 151-69 (1976 & Supp. V 1981).

112. Some commentators have suggested that the original version of the NLRA, Pub. L. No. 74-198, 49 Stat. 449 (1935), "was enacted largely because of the failure of American employers to modernize their concepts of industrial relations by giving employees an opportunity to participate in the determination of wages, hours, and working conditions." G. BLOOM & H. NORTHRUP, *ECONOMICS OF LABOR RELATIONS* 592 (1977). In effect the original version of the NLRA "put the power of the federal government behind the union organizer, assuring him that employees could choose whether or not to join a union without fear of employer interference." *Id.* at 593. The Labor Management Relations Act of 1947, Pub. L. No. 80-101, 61 Stat. 136, amended the 1935 act and shifted the balance of power back to the employer. *Id.* at 600-01, 629.

occurred before most health care workers were recognized as within the protection of the NLRA.<sup>113</sup>

Control over the decision-making process in these overlapping areas, however, could pose administrative problems. Medicare is administered by HCFA, a specialized agency of HHS.<sup>114</sup> An intertwining of the functions of the National Labor Relations Board with HCFA would be administratively unfeasible as well as undesirable in effect for both labor and management. Complex national policy objectives for health care and labor relations are not promoted by extending the jurisdiction of already specialized bureaucracies into unrelated areas of national importance. This difficulty would be evident when an NLRA-violating employer, cited by the NLRB, exercises its legal options of appeal in order to delay or negate the unfavorable disposition of its reimbursement requests.<sup>115</sup> Notwithstanding the double jurisdiction problem, the time lapse issue could be ameliorated by an agency rule that automatically denies medicare reimbursement for costs arising from activities found by the NLRB as violative of federal labor law. HHS, however, established no such trigger when the policy allowing unionization costs was adopted. Although violation of the NLRA was a benchmark of the outer limits for allowance of labor relations costs,<sup>116</sup> no serious enforcement mechanism was designed for screening providers' claims relating to counter-unionization activities. Another problem arises when the question involves state, county or municipal hospitals, as such institutions ordinarily are subject only to state labor laws, not to the NLRA.<sup>117</sup> Under the Reagan administration rule, those hospitals would never be denied reimbursement for anti-unionization costs as the providers could not be held in violation of the NLRA.<sup>118</sup>

Another apparent inconsistency with a rule of nonreimbursement arises due to the Internal Revenue Code's<sup>119</sup> treatment of an employer's persuasion costs. Under federal income tax law, an employer may deduct from its gross income business-related management and labor consultant fees if they are both "ordinary and

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113. *See supra* notes 18-22 and accompanying text.

114. *See supra* note 2.

115. This delay would frustrate the medicare objective of ensuring current payment to health care providers. *See supra* note 97.

116. *See supra* note 46 and accompanying text.

117. *See, e.g.*, Camden-Clark Memorial Hospital, 221 N.L.R.B. 945 (1975) (non-profit hospital found to be a political subdivision of the state is exempt from NLRA jurisdiction).

118. *See supra* notes 46 and accompanying text.

119. I.R.C. §§ 1-9602 (West 1974 & Supp. 1983).

necessary" in the statutory sense.<sup>120</sup> Previously, HCFA had dismissed this conflict with a "separate spheres" argument by explaining that "[t]he Internal Revenue Code differs in nature and purpose from the Medicare law. Treatment of costs unrelated to patient care under the Code is irrelevant to the allowability of such costs under the Medicare law."<sup>121</sup> Thus, medicare policy and federal tax law are other areas in which national policy implementation intersects but does not necessarily mesh.<sup>122</sup> The Internal Revenue Service's position is erroneous. Costs of persuasion, which reflect merely the employer's preference to employ unorganized workers, are not "necessary" to the conduct of business. This preference falls outside of the business-judgment doctrine<sup>123</sup> and persuasion expenses should therefore be held nondeductible.<sup>124</sup> Tax policy notwithstanding, the emphasis under medicare reimbursement focuses on concerns dissimilar from those measures designed to raise federal revenue by taxing enterprises that operate in the private sector.

Prior to January, 1982, comparisons to other statutory schemes were not successful in convincing HHS officials to permit medicare reimbursement of health care employers' costs to contest employee organizing efforts. The attempted synchronization with the NLRA was doomed from the outset due to both administrative difficulties and the exclusion from NLRA coverage of many affected providers operated by local governmental units. While the implementation of section 107 will not alleviate certain inconsistencies in federal law related to this issue, it will be fundamentally egalitarian in effect as it applies with equal force to all health care providers participating in the medicare program.

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120. I.R.C. § 162(a) (West 1974 & Supp. 1983) provides that: "There shall be allowed as a deduction all the ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business." *Id.* See 46 Fed. Reg. 3,985 (1982).

121. 46 Fed. Reg. 3,985 (1982).

122. See *supra* text accompanying notes 110-13.

123. The "business-judgment" rule allows deductions for reasonable business expenses if a reasonable person in that business would have incurred such an expense; in other words, a court would not "second guess" a business person's judgment. *Contra* Friedman v. Delaney, 171 F.2d 269 (1st Cir. 1948).

Sound public policy reasons exist for disallowing employer tax deductions for the cost of persuasion. The Internal Revenue Service, however, has interpreted I.R.C. §§ 162(c), (f), and (g) as covering the field of non-deductibles based on policy concerns. 26 C.F.R. § 1.162-1(a) (1982).

124. Ironically section 107 was passed as part of the package in the Tax Equity & Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324, 337 (1982). Perhaps Congress also should have examined the Internal Revenue Service's treatment of employers' persuasion costs.

B. *Distinguishing Reimbursable from Non-Allowable Costs of Labor-Relations Activities*

When HHS revised the rule in January, 1982 to allow costs, the agency contended that it had become administratively impracticable to distinguish costs of persuasion from certain other allowable costs. Because "reasonable costs" included the 'informing' of employees and obtaining outside consultants "to familiarize supervisors and employees with labor law," analysis of provider motivation was the alleged obstacle to "allocat[ing] costs between those attributable to 'persuasion' and those attributable to 'information'."<sup>125</sup> Employers, nevertheless, are already obligated to provide this information to the United States Department of Labor (DOL) pursuant to the Labor-Management Reporting & Disclosure Act of 1959 (LMRDA).<sup>126</sup>

In addition to setting out a "Bill of Rights for Members of Labor Organizations",<sup>127</sup> the LMRDA requires employer reports on both activities conducted and expenditures made to resist employee unionization.<sup>128</sup> Under the LMRDA, the employer is required to inform the DOL regarding any arrangement with or payment made to

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125. Transmittal No. 261, *supra* note 4.

126. Pub. L. No. 86-257, 73 Stat. 522 (1959) (codified at 29 U.S.C. §§ 401-531 (1976 & Supp. V 1981)). The preamble to the LMRDA (also known as the Landrum-Griffin Act) reaffirms the employees' right to organize for collective bargaining purposes: "The Congress finds that, in the public interest, it continues to be the responsibility of the Federal Government to protect employees' right to organize, choose their own representatives, bargain collectively, and otherwise engage in concerted activities for their mutual aid or protection." 29 U.S.C. § 401(a) (1976).

127. 29 U.S.C. § 411 (1976).

128. *Id.* § 433(a)(3) (1976). Reports must be filed by an employer who makes any expenditure, during the fiscal year, where an object thereof, directly or indirectly, is to interfere with, restrain, or coerce employees in the exercise of the right to organize and bargain collectively through representatives of their own choosing, or is to obtain information concerning the activities of employees or a labor organization in connection with a labor dispute involving such employer, except for use solely in conjunction with an administrative or arbitral proceeding or a criminal or civil proceeding. . . .

*Id.* The subsection's language apparently contemplates that the employer must violate section 8(a)(1) of the NLRA which declares it illegal for an employer "to interfere with, restrain, or coerce employees in the exercise of the rights [to organize and to bargain collectively] guaranteed in section 7." 29 U.S.C.A. § 158(a)(1) (West 1974 & Supp. 1983). Congressional intent, however, was to require "[f]ull reporting and public disclosures by employers of expenditures for the purpose of persuading employees to exercise, not to exercise, or as to the manner of exercising their rights to organize and bargain collectively . . ." SENATE COMM. ON LABOR AND PUBLIC WELFARE, LABOR-MANAGEMENT REPORTING AND DISCLOSURE ACT OF 1959, S. REP. NO. 187, 86th Cong., 1st Sess. 2-3, *reprinted in* 1959 U.S. CODE CONG. & AD. NEWS 2318, 2319. For an excellent synthesis of the legislative history and purpose behind LMRDA's persuasion-related reporting requirement, see *Donovan v. Master Printers Ass'n*, 532 F. Supp. 1140, 1141-44 (N.D. Ill.

an independent consultant<sup>129</sup> whose function is to dissuade employees from exercising their right to unionize.<sup>130</sup> The consultant must also report the nature of its arrangement with the employer.<sup>131</sup> By statutory mandate, then, health care employers are obligated to state in detail these anti-unionization activities.<sup>132</sup>

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1981), *aff'd*, 699 F.2d 370 (7th Cir. 1983), *cert. denied*, 52 U.S.L.W. 3509 (U.S. Jan. 10, 1984) (No. 83-599).

129. LMRDA defines a "labor relations consultant" as "any person who, for compensation, advises or represents an employer, employer organization, or labor organization concerning employee organizing, concerted activities, or collective bargaining activities." 29 U.S.C. § 402(m) (1976). The Act broadly defines the term "person" as "one or more individuals, labor organizations, partnerships, associations, corporations, legal representatives, mutual companies, joint-stock companies, trusts, unincorporated organizations, trustees, in cases under Title 11, or receivers." 29 U.S.C.A. § 402(d) (West Supp. 1974-1982).

130. 29 U.S.C. § 433(a)(4) and (5) (1976). An employer is required to file a report when in a fiscal year there is an "agreement or arrangement" between it and a consultant who then "undertakes activities where an object thereof, directly or indirectly, is to persuade employees . . . as to the manner of exercising the right to organize and bargain collectively through representatives of their own choosing. . . ." *Id.* § 433(a)(4). Further, a report must be filed when "any payment (including reimbursed expenses) pursuant to [such] . . . an arrangement" is made. *Id.* § 433(a)(5). *See generally* Annot., 3 A.L.R. FED. 770 (1970).

131. 29 U.S.C. § 433(b) (1976). The congressional intent of this subsection was to require the filing of

[f]ull reports by any person who has an agreement with an employer to persuade employees to exercise or not to exercise or as to the manner of their exercising their rights to organize and bargain collectively; or who supplies information to an employer concerning the activities of employees or labor organizations in connection with a labor dispute.

S. REP. NO. 187, *supra* note 128, at 3, *reprinted in* 1959 U.S. CODE CONG. & AD. NEWS 2319.

While LMRDA exempts from its disclosure requirements "any information which was lawfully communicated to such attorney by any of his clients in the course of a legitimate attorney-client relationship," 29 U.S.C. § 434 (1976), attorney persuaders nonetheless are not exempt from a required § 433(b) filing. *Wirtz v. Fowler*, 372 F.2d 315, 324 (5th Cir. 1966). *See also supra* note 129.

In *Douglas v. Wirtz*, 353 F.2d 30 (4th Cir. 1965), *cert. denied*, 383 U.S. 909 (1966), the court held that pursuant to section 433 of the LMRDA an employer's attorney must also report

all income and expenditures in connection with labor relations advice and services, given or rendered aside from the persuasion activities, if the attorney has within the same reporting period also either acted or received payment . . . under § (b)(1). Consistently, he would not be required to report fees and expenses for independent advice if there has been neither a persuasion service performed, nor payment for a previous service received, in that year.

*Id.* at 32. *Accord Price v. Wirtz*, 412 F.2d 647 (5th Cir. 1969) (rejecting its earlier position taken in *Fowler* specifically to follow *Douglas*). *See* Annot. 3 A.L.R. FED. at 780-86.

132. 29 U.S.C. § 439(d) (1976): "Each individual required to sign reports under sections 431 and 433 of this title shall be personally responsible for the filing of such reports and for any statement contained therein which he knows to be false." *Id.* Wilful

In view of the DOL reporting requirements, it may therefore be asserted that the monitoring of medicare reimbursement for provider costs in these matters should not raise administrative barriers as duplicates of the reports filed with the DOL<sup>133</sup> could be *prima facie* evidence of provider intent regarding persuasion expenditures. This assertion, while appealing at first glance, does not withstand analysis. Although the statutory scheme of the LMRDA lends itself to assisting in the determination of allowable costs in close cases, the current DOL interpretation of the employer reporting provision of the LMRDA<sup>134</sup> prevents adequate monitoring of provider costs because it assures the *secrecy* of management-consultant activities.<sup>135</sup> Contradicting the original Congressional intent,<sup>136</sup> this administrative interpretation requires employer advisors or consultants in unionization drives to report to DOL only when these third-parties are in direct contact with the employees.<sup>137</sup> As most counter-unioni-

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violations, false statements or representations of a material fact, and failure to disclose or the making of a false entry will subject the violator to a fine of "not more than \$10,000" or imprisonment "for not more than one year, or both." *Id.* §§ 439(a),(b),(c). The employer reporting provisions, however, do not imply a private right of action that unions can bring against employers or employer-agents; only the Secretary of Labor can enforce its provisions. *International Union, UAW v. National Right to Work Legal Defense and Education Foundation, Inc.*, 590 F.2d 1139, 1155 (D.C. Cir. 1978).

133. Employer and 'persuader' reports filed pursuant to the LMRDA are public information, available upon request for inspection and examination. 29 U.S.C. § 435(a), (b) (1976).

134. 29 U.S.C. § 433 (1976).

135. AFL-CIO News, Dec. 25, 1982, at 2, col. 4.

136. The purpose of section 203 of the LMRDA was to require employer reporting "of all agreements with independent contractors" involving counter-unionization efforts regardless of the specific role played by the management consultant in those efforts. Conference Rep. No. 1147, 86th Cong., 1st Sess. 32 *reprinted in* 1959 U.S. CODE CONG. & AD. NEWS 2503, 2504. Recognizing that "large sums of money are spent in organized campaigns on behalf of some employers for the purpose of interfering with the right of employees to join or not to join a labor organization of their choice," Congress contemplated that employers would be required to report their arrangements with intermediaries hired to combat employee organization. S. REP. No. 187, 86th Cong., 1st Sess. 10 *reprinted in* 1959 U.S. CODE CONG. & AD. NEWS 2318, 2327. Mandated disclosure of such behind-the-scene arrangements was a desirable policy "for if the public has an interest in preserving the rights of employees then it has a concomitant obligation to ensure the free exercise of them." *Id.* at 11, *reprinted in* 1959 U.S. CODE CONG. AD. NEWS 2327.

As recently stated by a district court judge: "The record is replete with evidence that Congress believed that 'union busting' management middlemen were working with employers to undermine employees in their attempt to exercise their § 7 [of the NLRA] rights." *Donovan v. Master Printers Ass'n*, 532 F. Supp. 1140, 1149 (N.D. Ill. 1981), *aff'd*, 699 F.2d 370 (7th Cir. 1983), *cert. denied*, 52 U.S.L.W. 3509 (U.S. Jan. 10, 1984) (No. 83-559).

137. AFL-CIO News, Dec. 25, 1982, at 2, col. 4. *But see* 29 C.F.R. § 406 (1982)



zation practices and activities directed by these management consultants are implemented through the employer's supervisory staff,<sup>138</sup> an extensive anti-union campaign can be waged while the real protagonist, the consultant, is thoroughly insulated from LMRDA requirements. Thus, without DOL interpretation and enforcement in accordance with Congressional intent, the LMRDA realistically could not provide the HCFA with the information needed to determine which costs are reimbursable under law.

The implementation of any verification process will nonetheless be facilitated greatly by a recent amendment to the medicare law.<sup>139</sup> This addition provides that authorized representatives of HHS or the Comptroller General must be allowed access to contracts for services and to books, documents and records of those services if the contract is between a provider and a subcontractor.<sup>140</sup> In essence, the determining agent could examine the records of the labor relations consultant to discern more readily which costs would be allowed as "necessary" to patient care.<sup>141</sup>

To summarize, ultimate responsibility for allowance of cost reimbursement rests with the HCFA, an agency possessing the expertise to handle difficult questions of fact regarding which

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and *Donovan v. Master Printers Ass'n*, 532 F. Supp. 1140, *aff'd*, 699 F.2d 370 (7th Cir. 1983), *cert. denied*, 52 U.S.L.W. 3509 (U.S. Jan. 10, 1984) (No. 83-599).

The Secretary reads § 203(b) to require the reporting of receipts and disbursements for *all* clients who received any labor relations advice if a labor consultant engages in *any* persuader activity. Thus, the Secretary treats the rendering of persuader services as a trigger which compels full disclosure of information otherwise non-reportable under § 203(c).

*Donovan v. Master Printers Ass'n*, 532 F. Supp. at 1144, *aff'd*, 699 F.2d 370 (7th Cir. 1983), *cert. denied*, 52 U.S.L.W. 3509 (U.S. Jan. 10, 1984) (No. 83-559).

138. AFL-CIO News, Dec. 25, 1982, at 2, col. 4.

139. Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 952, 94 Stat. 2646 (1980) (codified at 42 U.S.C. § 1395x(v)(1)(I) (Supp. V 1981).

140. *Id.* See Proposed Rule, 47 Fed. Reg. 44,750, 44,755 (1982) and Final Rule, 47 Fed. Reg. 58,260, 58,267 (1982) (to be codified at 42 C.F.R. §§ 420.300-420.304).

If a contract between a provider and a subcontractor covers services valued at or costing \$10,000 or more over a 12-month period, Medicare reimbursement cannot be made for the services unless the contract included a clause allowing the Secretary of Health and Human Services and the Comptroller General and [sic] access to the contract and to the subcontractor's books, documents and records necessary to verify the costs of the contract. The clause in the contract must also permit similar access to any subcontract between the subcontractor and a related organization of the subcontractor when the subcontract is worth or costs \$10,000 or more over a 12-month period.

47 Fed. Reg. 44,750.

141. See 42 C.F.R. § 420.304 (198—) for procedure to be taken to obtain access to subcontractor records.

management-type costs will be reimbursed by the medicare trust funds. Even without official DOL assistance in difficult cases, it is unlikely that HCFA would become overburdened by providing the type of analysis needed to decide the issue of allowability. Administrative inconvenience is not a factor because the recent addition to the law virtually assures the HCFA access to the business records of parties in contract with health care providers.

*C. Provider Unionization Costs Are Not Related to Patient Care*

Some health care institutions have insisted that the costs of persuasion actually are related to patient care, advancing the theory that full information about unions from the employer to its employees is essential to "maintain a smooth functioning environment" in the hospital.<sup>142</sup> Using the tests or objectives promulgated within the federal regulations,<sup>143</sup> the HCFA has made a reasonable distinction to rebut this contention:

Provider negotiations with provider employees with respect to wages, benefits and conditions of employment are clearly necessary to delivery of patient care whether conducted through individual or collective bargaining. The same is not true for activities designed to influence employees with respect to whether or not to conduct their negotiations with the provider on an individual or a collective basis, since either basis can be and is used in the provision of patient care.<sup>144</sup>

Thus, collective bargaining costs, because they are essential to the operation of the institution, are allowable; persuasion costs, however, are not in any sense necessary to the health care function and are not reimbursable. With the enactment of section 107, HHS is expected to reaffirm the reasoning behind the two-tiered approach, initially articulated in 1979.<sup>145</sup> Section 107's "directly related" activities requirement, however, may open the door to allowing costs for activities that incidentally influence employees regarding the decision to unionize.<sup>146</sup> An interpretation of section 107 that would disallow all labor relations costs save those necessary to implement a collective bargaining agreement would therefore be consistent with congressional intent and administratively nonburdensome.

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142. 46 Fed. Reg. 3,983, 3,984 (1981).

143. See *supra* notes 96-103 and accompanying text.

144. 46 Fed. Reg. 3,983, 3,984 (1981).

145. See *supra* text accompanying notes 26-29.

146. See *supra* note 8 and accompanying text.

#### D. *Government Neutrality in Labor-Management Affairs*

A cornerstone of national labor policy has been to maintain the federal government's neutrality in private sector labor-management relations.<sup>147</sup> Hospitals unsurprisingly protested that failure to receive reimbursement for persuasion costs was a clear signal from the government disfavoring their position against collective bargaining.<sup>148</sup> To do otherwise, however, would place the financial resources of the medicare trust fund behind an employer wishing to mount an anti-union campaign; such government action would be inconsistent with the spirit and purpose of the medicare act.<sup>149</sup> Clearly, the neutrality doctrine is razed by federal funding of employer anti-union activities.

Regardless of the employer's statutory obligation to bargain in good faith,<sup>150</sup> even reimbursement of collective bargaining costs could have a detrimental effect on the good faith principle. Because expenses for collective bargaining negotiations are allowable as costs related to patient care, the hospital, as the employer, has federal financial assistance that "may have the effect of encouraging employers to prolong union negotiations which, in turn, may force employees and their trade associations into arbitration which can be costly and time consuming."<sup>151</sup> HCFA, perhaps naively, has indicated its confidence in the health care institutions to be "concerned with providing quality care" and not to "jeopardize patient care by unnecessarily prolonging labor disputes with employees."<sup>152</sup> Both the neutrality doctrine and the legislative purpose of medicare are

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147. *E.g.*, 29 U.S.C. § 401 (1976). *See supra* note 112.

148. *See* 46 Fed. Reg. 3,983, 3,984 (1981). HCFA responded to this charge:

It is not our intent, nor do we have the authority, to interfere with a provider's operating and management decisions. In promulgating this policy, we do not intend to deny or diminish the rights of provider management to foster employer-employee relationships that may or may not be pro-union. Our policy is intended to insure that only costs related to patient care are reimbursed under the Medicare program.

*Id.* at 3,984-85.

149. *See supra* notes 11-16 and accompanying text.

150. Section 8(d) of the NLRA (29 U.S.C. § 158(d) (1976)) in essence defines the good faith principle as

the performance of the mutual obligation of the employer and the representative of the employees to meet at reasonable times and confer in good faith with respect to wages, hours, and other terms and conditions of employment . . . but such obligation does not compel either party to agree to a proposal or require the making of a concession. . . .

*Id.*

151. 46 Fed. Reg. 3,983, 3,985 (1981).

152. *Id.*

best served, therefore, by a policy of non-reimbursement whenever labor-management conflict is the source of provider costs.

E. *Legislative Purpose: Cost Effectiveness Questions and Control of Health Care Costs*

The legislative policy behind the "reasonable cost" principle is the rational allocation of trust fund monies to advance health care for the aged and disabled.<sup>153</sup> Recognizing this policy, hospitals have contended that anti-unionization expenses would be cost effective if the institution is successful in preventing employee collective bargaining.<sup>154</sup> This contention rests on the legitimate assumption that employees who bargain on an individual basis are less effective than those who negotiate through a union.<sup>155</sup> Over the short run, hospital employers, willing to expend substantial amounts for counter-unionization efforts, may undoubtedly grant higher wages or benefits to deter employees from unionizing. Nonetheless, under the regulations, providers are expected to pay salaries at rates not in gross excess of the prevailing wage scales.<sup>156</sup> Criteria set forth in the regulations ensure that, unionized or not, a hospital will receive medicare reimbursement for no more than the reasonable costs for expenses found to be necessary and proper.<sup>157</sup> Viewed from this perspective, the cost effectiveness theory appears based on dubious reasoning as no provision of the medicare scheme contemplates the depression of employee wages as essential to provider reimbursement.

Restrictions on the "reasonable cost" principle have the effect of shifting health care costs either to patient-consumers not covered by federal health insurance or to medicare recipients who often would be unable to pay the disallowed costs. Under the principle of cost apportionment, providers may not receive reimbursement for costs

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153. *E.g.*, S. REP. NO. 404, 89th Cong., 1st Sess. 4 (1965).

154. 46 Fed. Reg. 3,983, 3,984 (1981).

155. *Id.*

156. *See* 42 C.F.R. § 405.451(a) (1982). Also, 42 C.F.R. § 405.451(c)(3) (1982) declares that "[t]he reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed the actual costs of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same providers." *Id.* "This is subject to a limitation where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors." *Id.* § 405.451(c)(2).

157. *Id.* § 405.451(a), (b).

incurred to provide health care to non-medicare beneficiaries.<sup>158</sup> Any shifting of general costs from medicare to non-medicare patients has not been, however, a consideration in developing reimbursement principles, although health care strategists often assume a free-market approach to health care.<sup>159</sup> A broader, more integrated national health care system would require an accounting of all such expenses incurred through treatment of every patient, subject to direction under established legislative goals.<sup>160</sup>

The effect of cost apportionment on the non-reimbursement of unionization simply is that, under the present medicare system, those patients who are not covered by medicare will probably bear the providers' cost of persuasion. Whether the lack of congressional concern regarding shifting health care costs to those who are non-beneficiaries of medicare may be inferred from the enactment of section 107 is debatable.<sup>161</sup> Nonetheless, the emergence of public control, through activism in Congress and the state legislatures, over all health care costs is a recurring theme in any recent analysis of federal health insurance issues.<sup>162</sup>

In general, the medicare and medicaid provisions of TEFRA, while designed to reduce federal expenditures,<sup>163</sup> also indicate a congressional dissatisfaction with the current administration of health care programs. This sentiment was translated into legislative meas-

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158. See *supra* notes 83, 95 & 99 and accompanying text.

159. In theory, the health care consumer's ability to make rational market choices to maximize utility will cause in the aggregate the optimal resource allocation of medical services. Realistically, this ability is nonexistent, at least with the "consumption" of hospital services. As expected, the effects of medicare and medicaid—an increase in the public's ability to demand health care with little incentive for institutional cost containment—have "produced an inflationary impact on the cost of services." Weiner, "*Reasonable Cost*" *Reimbursement for Inpatient Hospital Services under Medicare and Medicaid: The Emergence of Public Control*, 3 AM. J.L. & MED. 1, 3-4 (1977). See also FEDER, *supra* note 11, at 2.

160. Commentators have noted that the primary objectives of medicare policy implementation have been to ensure provider participation; hence, the program's emphasis has been on the payment of claims, rather than on the development of a broad national health system. See, e.g., FEDER, *supra* note 11, at 3, 143-56.

161. As excessive federal health care costs would result in tax increases or a shifting of program priorities, national policy makers, the Congress and the Executive, have an interest in the cost-containment issue. FEDER, *supra* note 11, at 4.

162. Weiner, *supra* note 159, at 46-47.

163. See *supra* notes 55-60 and accompanying text. The federal expenditure for medicare for fiscal year 1982 is estimated to be \$33.4 billion. N.Y. Times, Oct. 7, 1982, at A24, col. 6. Recently, the cost of the program has been rising steadily at an annual rate of approximately 15%. *Id.* at A1, col. 6; see also REPORT, *supra* note 2, at 2.

ures proposed to contain cost increases charged by the providers.<sup>164</sup> Although dependent upon federal funding, as envisioned by the original proponents of the medicare scheme,<sup>165</sup> the current health care system mandates extensive decision-making by the regulated parties, the providers of health care.<sup>166</sup> The flexible standards of "reasonable cost" reimbursement<sup>167</sup> still allow a health care industry, essential to our national welfare, to dictate through a guaranteed but controlled market how the health care resources are to be distributed. Control over the allocation process incorporates great weight in the decisions regarding the costs of health care. Cost reimbursement issues, like the cost of persuasion question, indicate a congressional willingness to step into the fray, perhaps to transfer control over health care costs<sup>168</sup> from the providers to the public through the legislative process.<sup>169</sup>

Congruent with further government control over health care costs, and in accordance with provisions of the 1982 tax act,<sup>170</sup> for-

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164. See title I of the Tax Equity & Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324-395.

165. After the establishment of the medicare system, the providers' net income increased substantially. Weiner, *supra* note 159, at 13. Typically, any excess revenue received would be utilized for major capital expenditures, thus generating increased provider operating costs. *Id.* Provider expansion, however, was compatible with the medicare policy objective of increasing the availability of quality health care. See *supra* notes 11-16 and accompanying text.

166. See Weiner, *supra* note 159, at 1-47.

167. See *supra* note 93 and accompanying text.

168. In fiscal year 1981, \$243 billion dollars were spent for personal health care; almost 40% of that figure came from public funds: federal contributions for medicare and medicaid, \$71 billion; state and local governments' share of medicaid, \$26 billion. HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH CARE FINANCING TRENDS VOL. 3, No. 1, 1 June 1982.

169. See Weiner, *supra* note 159, at 46-47. This reallocation of power in the policy-making process was recognized by commentators during the 1970's:

The trend is toward the characterization of rate making as rate *regulation* (focusing on cost *evaluation*) rather than rate *setting* (focusing on cost *finding*). The regulated parties—the hospitals—will no longer be the principal decision-makers. Characterized as rate *regulation*, the rate making process must maintain a careful balance of hospital and public needs, correcting the hospital-favoring approach created by HEW's earlier implementation of the "reasonable cost" provisions of the 1965 Medicare and Medicaid statutes.

*Id.* (At the time of his article's publication, Weiner served as chair of the Massachusetts Rate Setting Commission.)

170. Section 101(b)(3) of the Act provides:

(c) The Secretary shall develop, in consultation with the Senate Committee on Finance and the Committee on Ways and Means of the House of Representatives, proposals for legislation which would provide that hospitals, skilled nursing facilities, and, to the extent feasible, other providers, would be reimbursed under title XVIII of this [Social Security] Act on a prospective basis. The Sec-

mer HHS Secretary Schweiker proposed a new system of hospital reimbursement based upon "prospective financing."<sup>171</sup> Under this proposal, all hospitals would receive the same amount of reimbursement, at a rate fixed in advance, for health care to any medicare patient with a particular diagnosis.<sup>172</sup> Similarly, section 107 may be viewed as another indication of dissatisfaction with the status quo, that is, the industry's domination of the decision-making process regarding health care costs.

## V. CONCLUSION

Section 107 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)<sup>173</sup> prohibits reimbursement from the medicare trust funds to health care institutions for costs incurred to resist employee unionization. This congressional enactment ended a three year policy struggle over the issue of when medicare reimbursement should be allowed for provider costs regarding labor relations matters. In accordance with section 107, employer expenses for activities designed to persuade workers not to join or form a union are not allowable costs. Reasonable health care provider expenses for collective bargaining negotiations or employee contract implementation, however, are deemed to be related to patient care and are reimbursable costs under the medicare law. The federal government's neutral posture in labor-management affairs is advanced further by section 107, although reimbursement of certain provider collective bargaining negotiation expenses will still provide health care employers with a decided advantage at the negotiating table.

As an example of legislative activism in the area of medical costs, section 107 contains a substantive policy-laden message beyond the issue of health care cost containment: Anti-union activities should not be federally funded through social welfare programs.

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retary shall report such proposals to such committees not later than December 31, 1982.

Pub. L. No. 97-248, § 101(b)(3), 96 Stat. 335 (1982).

171. N.Y. Times, Oct. 7, 1982 at A1, col. 6.

172. *Id.* According to Secretary Schweiker, prospective financing proposals would diminish the beneficiaries' costs for "deductibles." *Id.* at A24, col. 5. Prospective financing theory holds that providers would be forced to economize in order to maximize profits or to be within the operating budget of the institution. Efficient delivery of health care below reimbursement rates would result in greater cash flow for the provider, while actual costs above the rate would create a loss to the institution. Realistically, the excess costs in the latter situation would be borne by the consumer-patient, possibly in the form of lower quality care.

173. 96 Stat. 337, § 107 (to be codified at 42 U.S.C. § 1395x(v)(1)(N)).

Nonetheless, along with measures like the congressional mandate for prospective cost allowances, section 107 represents a continuing trend of closer congressional scrutiny of the rapidly increasing cost of health care. The persuasion costs involved in the policy debate terminated by passage of section 107 were minute in comparison to overall federal health care expenditures. Yet, congressional response to public outcry against a policy of anti-unionization cost reimbursement indicates a propensity by Congress to shift control of at least some policy decisions regarding health care costs to the public via the legislative process. Absent an overall program akin to a universal comprehensive national health insurance that would reform the current method of reimbursing health care providers, public input into the health care process is preferable to provider domination of the decision-making process within the medicare system.

While the original purpose of medicare was to encourage health care providers' participation in a program that would guarantee adequate medical services to our nation's elderly and disabled,<sup>174</sup> medicare beneficiaries are now integral to the ability of hospitals and nursing facilities to sustain profits or even maintain operating expenses.<sup>175</sup> Payments for their care from the trust funds are an important part of the providers' income stream.<sup>176</sup> Therefore, government denial of reimbursement costs for hospitals' anti-unionization activities will not cause a mass exodus of providers from the medicare or medicaid programs. Similarly, the quality of services should remain unaffected by nonallowance of these types of expenditures. Because medicare increased a demand for health services in the United States,<sup>177</sup> federal health programs have been singled out as a prime cause of the escalation of medical care costs.<sup>178</sup> In light of the concern for health care cost containment, the legislated policy of denying medicare reimbursement for counter-unionization activities is in the overall national interest.

*Burt Cohen*

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174. See *supra* notes 11-16 and accompanying text.

175. See *supra* notes 165 & 168.

176. See *supra* note 163.

177. E.g., Weiner, *supra* note 159, at 3-4.

178. *Id.*